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Why do patients seek primary medical care in Emergency Departments? An ethnographic exploration of access to general practice.

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ABSTRACT

Objectives

To describe how processes of primary care access influence decisions to seek help at the Emergency Department (ED).

Design

Ethnographic case study combining non-participant observation, informal and formal interviewing.

Setting

Six GP practices located in three commissioning organisations in England.

Participants and methods

Reception areas at each practice were observed over the course of a working week (73 hours total). Practice documents were collected and clinical and non-clinical staff interviewed (n = 19). Patients with recent ED use, or a carer if aged 16 and under, were interviewed (n = 29).

Results

Past experience of accessing GP care recursively informed patient decisions about where to seek urgent care, and difficulties with access were implicit in patient accounts of ED use. GP practices had complicated, changeable systems for appointments. This made navigating appointment booking difficult for patients and reception staff, and engendered a mistrust of the system. Increasingly, the telephone was the instrument of demand management but there were unintended consequences for access: some patient groups, such as those with English as an additional language, were particularly disadvantaged, and the varying patient and staff semantic of words like 'urgent' and 'emergency' were exacerbated during telephone interactions. Poor integration between in and out of hours care and patient perceptions of the quality of care accessible at their GP practice also informed ED use.

Conclusions

This study provides important insight into the implicit role of primary care access in use of the ED. Discourses around 'inappropriate' patient demand neglect to recognise that decisions about where to seek urgent care are based on experiential knowledge. Simply speeding up access to primary care or increasing its volume is unlikely to alleviate rising ED use. Systems for accessing care need to be transparent, perceptibly fair, and appropriate to the needs of diverse patient groups.

ARTICLE SUMMARY

Strengths and limitations

- Helps explain how interactions in primary health care can influence help seeking behaviour.
- Draws attention to modifiable features of primary health care that have the potential to help reduce ED use.
- Provides a detailed description based on both actual observed practice and individual narrative
- Patients/carers interviewed may not be representative of all those self-referring to the ED. Recruitment of patients was via GP practices, and it is possible that they may either have 'an axe to grind' or be reluctant to criticise.

BACKGROUND

The number of people seeking urgent health care in Emergency Departments (EDs) has risen to record levels in the NHS in England, with over 2 million *monthly* attendances recorded for the first time in March 2016.(1) This has had significant implications for delivering national urgent care policy, as the increasing number of attendances has been associated with a continuing decrease in performance of the national 'four hour standard', whereby EDs should assess, diagnose, treat and either discharge home or admit to hospital teams within four hours of arrival at the ED.(1) Given that a significant proportion of ED attendances are self-referred (patients choose to attend ED, rather than going to their GP), are discharged with 'advice only' (treatment in an acute hospital setting was not required) and that ED attendances peak during the working day on a Monday,(2, 3) it is presumed that better access to primary care will relieve pressure on EDs. This in turn could improve the performance of EDs in the NHS and help them to deliver the four hour standard by reducing pressure on fixed resources of staff, clinical space and diagnostic support services.

Given this, and that access is considered to be a central feature of high quality health care,(4) it seems evident that initiatives to improve primary care access are of value. Rapid access to primary health care in England is incentivised, with reward based on performance in the annual patient survey in primary care. In response to this, many GP practices sought to implement the 'advanced access' model that has been adopted effectively in the USA,(5, 6) and impetus to increase the volume of GP appointments through extending access to weekends and evenings, for example, has grown. Criticism of these approaches has included that the emphasis on speed of access has been to the neglect of other, important, dimensions of access(7, 8) and oversimplify the problem. There have been conceptual and practical barriers to implementing change, both relating to advanced access (6) and increasing the volume of GP access, with initiatives such as the Greater Manchester Primary Care Demonstrator Evaluation failing to provide convincing evidence that increasing the volume of primary care access leads to a reduction in ED use.(9-11)

The factors that determine the choice of location of first health care contact for urgent problems are complex. A review examining influences on ED attendance across different health care systems found a differential impact of access to primary care although some studies were limited by their methods of analysis.(12) Recent quantitative analysis of the relationship between access measures in primary care and ED attendance in England have found that even after adjustment for potential confounders, patient reports of poorer access to primary care were associated with increased ED attendance.(2, 12-16) Qualitative studies of ED use often focus on 'appropriateness' of use and patient motivations for location of care seeking, highlighting discrepancies between patient and

provider views(17-23)Some qualitative data on ED use demonstrates the complexity of decisions about where to seek care, framing demand as rational. (19)

In order to understand in more detail how the processes of primary care access can affect the decisions made by patients over their choice of first contact healthcare provision for urgent problems, we designed an ethnographic study at the critical interface between the community and its primary care practice – the reception area and its team that implement the process of access to clinicians. Our objective was to provide a nuanced account of how interactions that take place when patients seek urgent primary health care might inform decisions to seek help at the ED.

METHODS

Design

We conducted an ethnographic case study of six General Practices. Multiple methods were employed to achieve detailed and contextual insight, including: non-participant observation, individual interviews, and analysis of documents. The ethnography research team comprised three social scientists (EB, FM, LW) and an academic GP (KC).

Setting and sampling

We chose six GP practices across three commissioning organisations (clinical commissioning groups). Using routine data from three years (2009-10, 2010-11, 2011-12), GP practices within each commissioning area were stratified into quintiles by rate of ED use and unplanned hospital admissions. These data were scrutinised to identify potential cases, e.g. practices which seemed to have lower unscheduled care use than might be expected given population characteristics (such as high levels of deprivation, large older population), pairs of practices with relevant shared characteristics but very different rates of unscheduled care use and practices that had moved significantly between quintiles. Selected practices varied in features such as size and diversity of the patient population, staffing and area deprivation (TABLE 1).

Table 1: Practice characteristics

Practice	Commissioning area	List size as percentage of commissioning area average	Quintile on Index of Multiple Deprivation	Full Time Equivalent GPs /1000patients (commissioning area average)	Observation period (total hours)
1	1	67.9%	2nd most deprived	0.476 (0.54)	Oct/Nov 2013 (18 hours)
2	1	139.5%	2nd most deprived	0.52 (0.54)	Feb 2014; May 2014 (14 hours)
3	1	58%	Most deprived	0.62 (0.54)	Feb 2014; May 2014 (14 hours)
4	2	209.6%	4th least deprived	0.5 (0.6)	June 2014 (10 hours)
5	2	225.6%	2nd least deprived	0.51 (0.6)	June 2014 (9 hours)
6	3	197.4%	2nd most deprived	0.54 (0.57)	July 2014 (8 hours)

A sample of patients/carers with recent experience of ED use were invited to interview. Participating practices generated anonymised lists of patients with recent (≤ 3 months) ED use. Those patients who had self-referred to the ED, who attended the ED during GP practice opening hours, who had no investigations while at the ED, and/or who were discharged with 'advice/guidance only' were approached first, as the potential to have had needs met in primary health care was considered to

be higher in this group. A range of clinical and non-clinical staff at participating practices were also invited to interview by the practice's research contact or during observation by the researcher. Informal interviews supplemented recorded staff interviews.

Data collection

Non-participant observation took place between October 2013 and July 2014. Consent was sought at the practice level for observations. Observation took place in the reception and 'back office' administrative areas, as we wanted to look at interactions with patients, between practice staff and between practice staff and other health care professionals to gain insight into practice factors and how these might influence patients' care seeking. The observing researcher wrote field notes in a notebook during events, or shortly afterwards. Much of what was observed was telephone interactions, and where necessary these were followed by informal discussion with staff to gain clarification. The observer also collected relevant documents (e.g., policies / guidelines for staff, meeting notes, patient information leaflets).

Staff interviews sought to get insight into their experiences of patients seeking urgent care and views of their workplace's policies and practices around access. In some instances the invitation was issued to all staff at a practice meeting or in staff pigeonholes and staff then approached the researcher to express interest. At other practices individual staff were identified and approached by the practice contact (e.g. research lead). The process was iterative, and some potential interviewees were identified by the researcher as a result of data collection. For example, at one practice, patient and staff interviewed frequently mentioned a particular GP, who seemed to be the preferred GP for patients with higher rates of ED attendance, and so this person was approached and subsequently interviewed. Interviews were audio-recorded with written consent and a topic guides was employed to facilitate discussion.

Patient/carer interviews sought to understand pathways to the ED and experiences and views of the practice. Identified patients (or carers for patients aged 16 and under) were sent invitation letters by their GP practice, with a reply slip to be returned directly to the researcher. As with staff interviews, patient/carer interviews were audio-recorded with participants' consent and a topic guide was used.

Analysis

Field notes and documentary analysis were transcribed into MS Word by EB. A structure to the typed field notes developed from the first two practices, which was applied to subsequent practices. This included: information about the practice (population, staffing, summary of results from the most recent GP patient survey etc.), description of the practice context, a diagram of the practice layout, and a description of observed interactions. The field notes were read to identify themes specific to the practice and also cross-cutting themes (e.g., 'Being dealt with/seen in a timely manner at reception or for booked care', and 'unscheduled secondary care – specific references'), and a description of these was written by EB. Interviews were transcribed verbatim by a professional transcriber then checked for accuracy and anonymised by FM. Transcripts were uploaded to NVivo 9. FM wrote an interpretive narrative of each transcript and then integrated these in a descriptive account for each practice. The ethnography research team met monthly to discuss the ongoing analysis.

Practice summaries and integration

Field notes and interview descriptive accounts for each practice were reviewed by FM. Over-arching themes relating to how interactions relating to urgent care at each practice influenced ED use were identified and these formed the structure of a case summary for each practice. Each summary was reviewed by the ethnography research team and key findings fed back to the wider research team for discussion. All six summaries were then evaluated together to identify key features of primary health care that influence use of unscheduled secondary care.

The results presented here show how dimensions of access to primary health care are implicit factors in patients' decisions to attend the ED. Results are illustrated with interviewee quotes and extracts from observational field notes; pseudonyms are used for all participants.

RESULTS

Seventy three hours of observation across six practices were recorded in total (TABLE 1). Nineteen members of staff were interviewed (TABLE 2): seven GPs, seven reception staff, four managers and one nurse practitioner. Twenty patients and nine parents/carers were interviewed (TABLE 3), 17 in their own homes and 12 by telephone. Ten patient interviewees spoke English as an additional language: none requested a translator.

Table 2: Staff interviews

Practice	Pseudonym	Role in practice
1	Elizabeth	Lead GP
	James	Reception/administration
	Sally	Reception/administration
	Michelle	Reception/Health Care Assistant
2	Charlotte	Reception and access manager
	Emily	GP
	Olivia	Lead GP
3	Matthew	GP
	Connie	Office manager,
	Paula	Medical secretary / receptionist
4	Becky	Audit controller
	Linda	Reception Manager
	Bronwyn	GP
5	Laura	Patient services manager
	John	GP
	Lindsay	Nurse practitioner/manager
6	Alexander	Reception/administration
	Leah	Quality improvement facilitator
	Sadiq	GP

Table 3: Patient/carer interviews

Practice	Pseudonym	Patient / carer	Sex	Age (age of patient)	Index ED use	English as a first language
1	Orla		Female	58	Multiple self-referral	Yes
	Emma		Female	26	Multiple self-referral	Yes
	Magda		Female	30	Single self-referral	No
	Liang		Male	30 (<1)	Multiple self-referral	No
	Daniel		Male	42	Multiple, plus admitted	Yes
	Candice		Female	48	Multiple, plus admitted	No
2	Jackson		Male	56	Single, plus admitted	Yes
	Sam		Male	48	Single self-referral	Yes
	Fadil		Male	34	Emergency services referral, plus follow up self-referral	No
	Zahirah		Female	28 (2)	Multiple self-referral	No
	Mo		Female	42	Single self-referral	Yes
3	Peter		Male	64	Single, plus admitted	Yes
	Ruby	Carer	Female	27 (2)	Multiple self-referral	Yes
	Sylvia		Female	72	Single self-referral	Yes
	Anna		Female	25	Multiple self-referral	No
	Marilyn		Female	68	Single self-referral	No
4	Rebecca		Female	26	Multiple self-referral	Yes
	Joan	Patient	Female	68	Single self-referral	Yes
	Gemma	Carer	Female	38 (5)	Multiple, plus admitted	Yes
	Noreen	Patient	Female	62	Single self-referral	Yes
	Gabriella		Female	44	Multiple self-referral	Yes
	Mitch		Male	44	Single self-referral	Yes
	Grace	Carer	Female	31 (3, 1.5)	Single (child1); Multiple (child2)	Yes
	Carol		Female	42	Multiple self-referral	Yes
5	Faith		Female	23 (4.5, 1)	Single (child1); multiple (child2) self referral	No
	Suzy		Female	40 (13)	Single self-referral	Yes
	Sharon		Female	31	Multiple self-referral	Yes
6	Aisha		Female	24 (<1)	Multiple self-referral	No
	Mehreen		Female	25 (<1)	Multiple self-referral	No

Whilst features of general practice were not usually explicitly stated by patients as factors in seeking help at the ED, they were implicit in patient accounts, and observed to be important determinants of patient behaviour during fieldwork.

Intricate appointment systems

Highly complex appointments systems that had evolved incrementally over time were typical. Both patients and reception staff found these obscure and hard to navigate; patients mistrusted them, and their operation was affected by the skills and experience of reception staff. Each practice had a unique appointment system, with a range of appointment categories and ways of allocating appointments. Nurse or GP-led telephone triage was used by several practices, and two (5 and 6)

encouraged patients to see the same doctor each time. A general shift towards same day appointments and telephone appointments/telephone triage was evident.

Patient/carer interviews revealed a degree of suspicion amongst patients, and this was recognised by reception staff: "t*hey [patients] think you're hiding appointments"* (Sally, Receptionist, GP practice 1). At practice 2, reception manager Charlotte commented: "*some patients sit in the reception waiting room to wait for the phone call. There's a perception that if they do that then they might be seen".* Factors contributing to a lack of confidence in access systems included ongoing incremental changes to systems that were not clearly communicated to patients and a reliance on the telephone for access. Telephone systems could be overloaded at the start of the day when same-day appointments were generally allocated and patients reported getting 'mixed messages':

> *On the Friday I rang and they said, "You'll have to ring back on Monday." And I said, "Well I need to speak to a doctor as well [as well as having a face to face consultation]," and they said, "That'll be next Thursday." I said, "What, a week to speak to a doctor?" But then I rang again on the Monday and somebody said, "Right, somebody will phone you back in two hours." (Mo, patient, GP practice 2)*

Complex appointment system meant reception staff have an important role in facilitating access. Receptionists at all practices engaged to some extent in patient triage, for example by determining level of urgency in appointment requests. Observation of newly appointed staff dealing with appointment requests suggested that knowledge of how the system worked was often tacit and uncodified (Box 1).

Box 1: Reception staff skills and knowledge (observation field notes)

Practice 4: One Monday morning in particular there were regular discussions about whether a doctor or a nurse was more appropriate, with receptionists sometimes seeming to be seeking to 'sell' nurses to patients by stating that they could prescribe, and that the wait might be shorter (Experienced receptionist Linda "Would you be happy to see a nurse practitioner? She can prescribe."). The new receptionist Beth was observed routinely asking patients if they needed to see a nurse or a doctor ("Do you need to see a doctor or can you see a nurse?"), effectively placing the responsibility on the patient to choose with the implied assumption that they knew who could deal with what. Some patients did know – for example they had past experience of a similar problem and knew it was unlikely to be something the nurse would be able to prescribe for. Others were more uncertain at being allocated this self-triage role by Beth.

09:01 A man with a young boy is being served by Beth. He says he was told on the phone to come down but there are now no appointments left with the person he wanted to see. Linda joins Beth and tells the man that the boy will be seen. She asks what the problem is. He says tonsillitis and Linda suggests that they see the nurse practitioner.

10:04 Beth is still asking people if the nurse can help. They sometimes respond with a description of the problem they are here about; they want her to triage/make the decision. She puts the man who is currently at the desk down for the nurse. His first language is not English and he continues trying to explain something to her. The more experienced receptionist, Linda, provided guidance and advice, helping the patient and steering them towards what she saw as the best option.

Reception staff were aware of how experience mattered: "*I wouldn't say everybody would know what to look for. I think it's a trained eye*" (Paula, Receptionist, GP practice 3), and Alexander, a receptionist at GP practice 6 describes how *"you have to kind of read between the lines most of the time"* when eliciting information from patients. When asked about how he would decide whether do pass a call to a nurse practitioner or a GP, he said: *"I would base it on the symptoms. I think, you know, having worked here this long I have a good understanding of what the nurse practitioners are capable of*".

For patients, reception staff were seen as 'gatekeepers', *"If you call you speak to a receptionist, you feel like you've got to get past that first, you know, enough to get an appointment"* (Grace, patient, GP practice 4). As discussed earlier, patients might feel that reception staff were obstructing access. However, observation suggested rather that staff used the system flexibly to facilitate access. In informal discussion Rhona, a receptionist at GP practice 1 told us: *"Sometimes we can manipulate the system, but we try to stick to the appointments".*

Each practice's system reflected their patient population and their priorities. Practice 2, with a significant Muslim population, introduced a Saturday morning clinic to accommodate patients who couldn't attend the practice on Friday afternoons, whilst Practice 1 was set up specifically to

enhance access for 'hard to reach groups'. In Practice 1 there was a significant focus on facilitating access for patients with drug and alcohol misuse problems or who were homeless (Box 2).

Box 2: Practice 1 - Meeting the needs of specific patient populations

Strategies exist to facilitate access to services, e.g., outreach work, maintaining good relationships with external groups such as homelessness charities, and use of the patient warning system:

With particularly vulnerable patients the GP will put a patient warning on…It will pop up a window in the middle of your screen which you have to acknowledge before you can carry on. So it's usually things like "Prioritise appointments with Dr Elizabeth" or permission to use embargo slots for this patient (James, reception)

The high proportion of these vulnerable patients on the list was often mentioned in interviews, with reception staff demonstrating awareness of their needs and life contexts, *"life's so chaotic anyway that they don't remember…we do have to bear in mind that they're not going by times and dates"* (Michelle, Reception/HCA). Observations showed that reception staff were familiar with dealing with drug or alcohol dependent and homeless patients and dealt with them calmly and patiently. Sometimes patients were provided with appointments or prescriptions outside of normal procedures due to a concern that they would "kick off" otherwise

In contrast, this flexible and accommodating approach was not generally applied to patients who had English as an additional language at practice 1. Reception staff experienced language barriers as problematic and disruptive:

> *We just have to try and work out what it is they're saying and we have to try and make ourselves understood and it is difficult. It's really difficult. There's no system currently in place to alleviate that and it's tricky to see how you could. I mean unless you have a member of staff, every single of member speaking a language…And those conversations take ages because you can't hang up if you don't understand (James, Receptionist, GP practice 1)*

As discussed earlier, the intricate systems we observed had generally arisen out of an ongoing process of monitoring and adjustment. For example, Practice 2 changed the number of telephone triage slots each week based on the previous three week's use. Two practices (5 and 6) were particularly focused on increasing efficiency by monitoring and changing their system. At practice 5, Practice Manager Graham described how appointments were allocated based on historical data. For example, Mondays were busy, and so had the highest number of emergency slots. Waiting times for specific doctors were also reviewed, and patients were switched between doctors' lists if waits exceeded 5 days. Practice 6 was unusual in adapting procedures for specific patient populations. For example, they found that telephone triage of young children generally led to face-to-face appointments, so they decided to offer appointments for young children without the need for triage. Alexander (receptionist) notes that the appointments system *"has been tweaked so much over the years*." However, this approach of incremental and reactive system changes--tweaking things—could

be problematic for patients. One patient interviewed, Aisha, said *"Do you know, with appointment it used to be easy? You'd book your appointment and then you'd go in to the doctor."* Similar feelings were echoed by patients at other Practices:

> *I tried to register again [for the booking system] and it was like, "We're not using this system now; we're using a different system." You try and register, and then I didn't ever receive like a confirmation email back and I just kind of gave up and thought, "Whatever, I'll just leave it." (Grace, patient at GP practice 4)*

Appointment availability

Most practices had incrementally increased same day appointments, telephone triage or telephone consultation slots. Staff were generally positive about telephone access/triage, as it reduced demand for face to face appointments and meant that there was always something to offer patients, even if this was simply an instruction to call back the next morning to access triage slots. This approach was common at Practice 1, where staff reported that that the triage list fills up within minutes:

> *There's six appointment slots. You never ever book into triage except on the morning. It's electronically locked until 8.00. People phone up at 8.00, so the phones usually go berserk. (James, receptionist)*

Most practices released same day appointments prior to the practice physically opening, favouring those with access to/preference for the telephone. Some features of appointment systems were opaque to patients; for example, patients from GP practice 1 were rarely aware that additional appointments were released in the afternoon. The existence of different types of appointment could be bewildering:

> *I am not very happy about this part of it. I could go down there now, drive down there and say I'd like to see Dr X or any of the doctors in our practice. .."Right um there's no appointments available until next week. But if you would like to ring at eight o'clock in the morning, tomorrow morning, we will fit you in as an emergency and you will see a doctor". (Peter, patient, GP practice 3)*

The provision of a same day appointments or telephone triage was arguably at the cost of routine appointments (Box 3). Demand for routine appointments was difficult to manage, with waiting times of between 4 and 14 days. Graham, practice manager at practice 5, suggested that this led patients to frame problems as urgent inappropriately. This lack of routine appointments frustrated patients, *"I need to know that I'm going to be ill about two weeks in advance*" (Rebecca, patient, GP practice 4). *A*n emphasis on telephone triage also had the potential to inhibit continuity of care or fulfilment of patient preferences. For example, stated preferences for a particular GP, or with a GP who was female, could not be met in some practices.

Box 3: Reliance on telephone triage (observation field notes)

At practice 2, the vast majority of people who contacted the surgery seeking a GP appointment were told that there were no face to face GP appointments at all available for them to book, and were either instructed to call back on another day to try and book a newly-released appointment a week in advance then, or if they could not wait this long they were offered a call back from the on-call doctor today. It seemed that many patients who would have been satisfied to book an appointment in a few days' time were ending up on the same day triage list because this was not an option.

Monday 08:47: Receptionist Donna, "At the moment all appointments booked for next Monday." "If you ring up today you basically get an appointment for next Monday, but they're all gone. If you need today I can put you down for a call". Patient asks about appointments. "No, nothing, tomorrow release more appointments which are for next Tuesday." Donna offers a call today again. Ends up booking patient into a telephone slot on Thursday after 12:30. Donna's next call: "We don't, they're all gone now." "OK sorry about that, bye, bye."

Weekend and evening appointments and 'walk in' (i.e. no appointment) clinics had been implemented by some practices to meet demand. Demand for appointments at walk in clinics was very high, putting pressure on facilities: in Practice 4 we observed 26 patients in the queue within 10 minutes of doors opening, and there were 47 people in the waiting area before 9am. Extended hours access also did not always work as intended. Practice 5 had evening and weekend access, ostensibly to facilitate access for working people:

> *I think sometimes it's not necessarily busy with the people that maybe need it: people that are working away, that work full-time, that was what it was intended for. But because we've got into a stage where patients couldn't see their doctor for six days, but there was a Saturday morning available, they go, "Oh yes I'll have that." (Laura, Patient Services Manager, GP practice 5)*

GP practice 4 had a higher number of working age patients than other practices, and lack of appointments outside of the working day was noted by three patients during interview.

Communication and talking on the telephone

Practices felt under great pressure: *"even if we worked seven days a week, 24 hours a day, we will never meet demand*" (Emily, GP, GP practice 2), and the telephone had become the instrument of demand management. Whilst practices saw this as beneficial ("*it is pretty much the only way to deal with it [demand]*" Sadiq, GP, GP practice 6), patients and carers interviewed expressed ambivalence about reliance on the telephone. Many appreciated that it could speed up access but also had a disinclination to speak with clinical staff by phone. The morning telephone rush could be problematic; *"some people miss out 'cos there are so many people calling at the same time* (Faith, parent, GP practice 5). Critically, reliance on the telephone had the potential to lead to inequitable access for some groups.

Patients with English as an additional language could be particularly disadvantaged by the telephone's dominance, and we observed notable variation in practice between GP Practices (Box 4), which appeared to drive some ED attendance (practice 1, Box 4). Aisha, parent of a young child at GP practice 6 expressed frustration at what she felt was a convoluted process of accessing care (via telephone triage), and that the outcome was often not worth the effort: *I'm struggling with my English, it's not very good, sometimes you don't know which words you need to use when you are ill. So when you can't explain they say, "You don't need to come here. Just get Paracetamol or Ibuprofen*."

Although only accounting for a small proportion of the patient population, those with hearing difficulties and deaf patients were also constrained by the reliance on telephones:

> ***Practice 2 field notes:*** *A man at the desk is saying "Very peculiar I can't see the doctor". There seems to have being a misunderstanding and he thought he was supposed to come in to see the doctor today but he does not seem to have an appointment. He is getting upset. It seems that he does not have a phone for the doctor to call him back. The receptionist says that she will go and ask the doctor he thought he was seeing. A little later I hear the man say that he is deaf and that he was told two weeks ago by the doctor to come in. He has been told that if he sits and waits Dr Emily will see him but they cannot tell him what time. He is not happy. He says it was Dr A who told him to come. "You make me crazy here. I can't phone, I come and you tell me it is full. I came last week. Any doctor, any week. When will I be able to book a doctor."*

Box 4. Contrasting examples of responding to patients with English as an additional language (observation field notes)

Facilitating access

Practice 2: A couple, who appeared to be Eastern European, come to the reception desk to say that it was past their appointment time but they had not been called. It turned out that they had not checked in when they arrived, as they did not understand that they needed to do this. Tracy responds by sending the doctor they were supposed to see a message to explain the situation and see if she could fit them in late, and she also explained to the couple what to do next time they came for an appointment.

Practice 6: A man comes to Sharon with a four-week-old baby asking about a BCG. Sharon takes him over to the community services desk. It looks like the man with the baby is having some language problems. Sharon asks what language he speaks and then sends for a colleague who speaks Arabic to come and help. …Sharon, to Arabic speaking colleague who has now arrived in reception: "This poor gentleman has been sent round the houses" and then she proceeds to explain what the issues are as she understands them. He will be sent another appointment for a BCG by community services, and then needs an eight week check (the original BCG appointment was missed)…Sharon is telling someone she will book an interpreter for an Arabic speaking man… Sharon is saying "Sorry you have been messed about" to the Arabic speaking man

Inhibiting access

Practice 1: The last walk-in appointment for today is given out at 16:31. The next man to arrive does not have English as a first language and talks about a "point" in his thigh. Lead receptionist Mary tells him that they have no appointments left and suggests that he call 111. He does this on his mobile phone from the waiting room but he doesn't seem to manage to speak to anyone. Mary suggests that he can come back tomorrow morning and he will be able to sit and wait, or he can go to A&E if it gets too bad in the interim.

Practice 4: 12:24 Beth comes in with a query. A man says he has not been called but the screen is showing him as having been called at 12:00. English is not his first language. Is it something about a sick note? No – he wants to talk to doctor to see what was wrong. Doesn't want to just go back to work. He still wants an appointment to check his health. He is told to phone at 08:30 tomorrow to get an appointment. I don't think he is clear on the instructions he has been given, plus phones very busy at 08:30, phone more challenging when English not a first language, and he wasn't told about the possibility of coming to the downstairs desk from 08:00 on.

Is it an emergency?

All GP practices had a proportion of same day appointments categorised as 'urgent' or 'emergency' appointments, both face to face and telephone. Urgent requests would always be met, usually via GP telephone triage. It was evident in interviews and observation that patients and staff often understood these terms differently, leading to frustration and confusion. Staff claimed that some patients sought urgent appointments inappropriately: *"They know how it works a little bit, so if there's no appointments then they'll make up that's its urgent*" (James, receptionist, GP practice 1). Staff also attributed the demand for urgent appointments to cultural and language differences:

> *I suppose a big thing that plays a factor with the language barrier is that a lot of patients don't really understand the terms 'urgent', 'routine'. A lot of them use the word 'emergency', "It's an emergency," and what they actually mean is – because emergency to us in healthcare is 999, it's a real emergency – whereas what they mean is that their child might have a high temperature (Charlotte, Reception Manager, GP practice 2)*

Long wait times for routine appointments led patients to frame their need as urgent when they otherwise might not. Mo, a patient at GP practice 2, reflects: *"When you needed to speak to a doctor, what do you define as urgent or not urgent, you know?…even if it was the next day, but a week is a bit much".*

'Urgency' was negotiated between patients and staff. Reception staff often supplemented the word 'urgent': *"We've only got medically urgent I'm afraid" "And it is definitely medically urgent?",* or using a timescale: "*Is it urgent for today*?" This then required patients to 'self-triage': "*I sort of say, "Well it's not an emergency-emergency, but I could do with being seen in the next day or so."* (Sharon, patient, GP practice 5). Some patients appeared uneasy with defining their request for an appointment as an 'emergency', and conversely others felt that receptionists should take requests at face value: *"I should know in myself that there is an issue with my mental health and I need to see somebody sooner rather than later, but I don't want to go into a deep rooted conversation with the receptionist". (Rebecca, patient, GP practice 4)*

Out Of Hours care

Complexity within the wider system, particularly around out of hours (OOH) care, could also influence ED use. There was largely a lack of clarity around where to access care out of hours, and there was a widely held view that GP care was only available within practice opening hours. In interviews patients often described not seeking care from primary health care prior to the index ED attendance, ""*I never thought of it*" (Sylvia, patient, GP practice 3). Some were aware of the non-emergency out of hours telephone line 'NHS 111', but did not know that this was a route to out of hours GP care. For other patients, previous experience and assumptions about the quality of OOH care precluded it from being considered a source of help. Gemma (patient, GP practice 4) had taken her daughter to appointments with OOH GPs but felt that they had focused on irrelevant symptoms. She reflects, "*We completely lost hope in the out of hours doctors*". Other participants, particularly those with long term conditions, found the lack of information available to out of hours doctors problematic:

> *it's an emergency appointment, and I'm in pain, and I'm looking for something to help...she was asking me all these questions about, you know, drug seeking and am I addicted and how long have I been taking these drugs? And she hadn't read the notes that led to that (Emma, Patient, GP practice 1)*

In contrast to OOH, experiences in the ED or using the NHS 999 emergency telephone number were largely positive. When asked what he would do about accessing care out of hours in future, Fadil (patient, GP practice 2) says, "*To be honest with you, I'll call 999*".

Practice staff felt that a lack of awareness of OOH services drove ED use: "*I don't think a lot of patients are aware of out of hour's services. I think if they were then A&E wouldn't be so snowed under*" (Michelle, Receptionist, GP practice 1). Practices did not seem to feel responsible for promoting OOH care: "*I'm not sure what we actually do, other than have a phone message*" (Sadiq, GP, GP practice 6).

Perceptions about level of care accessible at GP practice

Some patients who had attended the ED described their ED attendance as the fastest route to appropriate care. Grace (patient, GP practice 4) describes it as 'cutting out the middle man', drawing on experiences of accessing care to contextualise this:

> *I wouldn't necessarily have rung a GP surgery because I think they probably would have told me to go to A&E. I guess I'm second guessing myself, but in my head I think that when I try, you know, to get appointments on a day to day basis they generally don't have appointments, and if there was anything wrong they would probably refer me to A&E, so it's kind of a bit like cutting out the middle man.*

Some patients described being dissatisfied with care and questioned their GP's competence, or felt that the ED could offer them a level of specialist skill unavailable in primary health care. The ED provided a level of reassurance that some patients thought would not be possible in primary health care: "*it wasn't very nice being linked up to the ECG machine and having needles stuck in me, but felt like there was a lot more investigation done"(Rebecca, patient, GP practice 4).* Mitch (patient, GP practice 4) had a painful, swollen spot on his back that he thought might be an infected insect bite. Unlike most other participants, he had consulted the GP prior to attending the ED. He anticipated that the GP would want to lance the lump but was instead given antibiotics. Mitch was sceptical about whether these would work, *"I wasn't given any sort of advice going forward*." Subsequently, as the pain and swelling continued, he decided to go to the ED:

> *there probably was an alternative but I just thought to myself, "I wanna get this sorted," and I thought the best way to do it was to go to the A&E*

Despite babies and young children having preferential access to GP care (e.g., children under two offered same day appointments), parents/carers could feel that their views were disregarded by GPs and perceive that they received a better quality of care in the ED. Risk perception dominated parent and carer accounts (Mehreen's story, Box 5), so the ED was seen as more appropriate when they viewed problems as urgent.

Box 5. Patient story: Mehreen

Mehreen's 18 month old son was born 10 weeks pre-term and spent time in Neonatal Intensive Care. Mehreen felt that the decision to go to the ED the first time she attended with her son (for "very severe colic") was influenced by her experiences at NICU:

When he get discharged on that time they said like, "He is premature. If he has any problems straight away you can come into hospital."

More recently, Mehreen's son developed a fever that she managed at home with paracetamol for a few days. The fever wasn't responding to paracetamol and she went to the ED where *"they just gave the Ibuprofen to him*". Two days after returning home her son developed another fever and she took him back to the ED. This time they investigated to see if there was an infection (urine sample, x-ray, blood test) but no underlying cause was found and the fever diminished while they were at the ED. Mehreen contrasts primary health care with the ED, she feels that in both places she is treated "nicely" but that the quality of care and availability of equipment to investigate problems in the ED is better:

It is different because in the hospital there are really very – give very good – provide very nice care to my baby

Mehreen says that she didn't think to contact her GP because her son's fever was always at night, but her narrative suggests factors that influenced where to seek help other than GP availability. For example, she felt that the call back system does not lead to timely care, and this is especially important in the context of young children:

We have to wait for the doctor's call, because sometimes it's really very emergency and we have to ring to the GP in the morning time because they don't give any appointment if we ring at 12 o'clock, but if we ring before 8 o'clock or 9 o'clock then they give the appointment on the same day. Yeah so I don't like that thing: they need to improve it...Like if we had any emergency at one o'clock, they don't give any appointment on the same day. That's why we prefer go the emergency, because we know the kids are very important in everyone's life.

Along with an expectation that she won't get a timely GP appointment, especially if she calls later in the day, Mehreen feels that concerns about her baby are often dismissed or minimised:

If we went to the GP I don't think so they bother anything…the GP they just said like, "There is not any problem, your kids are happy, there is not anything to worry about it." Because we are mums so we definitely worried about our babies' lives… I know they just give Paracetamol

DISCUSSION

Patients seeking care at the ED often doubted primary health care's capacity to respond to 'urgent' problems. This belief results from cumulative past experience of care seeking. Dimensions of access to primary health care were implicit in all patient accounts of ED use, and observation of practice evidenced these. Different dimensions interacted with one another, and with other features of primary health care such as relational continuity. We found that GP practices had complex appointments systems that had often evolved incrementally and reactively, with new approaches 'bolted on' to try and manage demand. Patients found them obscure and were mistrusting of them; reception staff were required to help patients navigate appointments, which privileged tacit knowledge and expertise. Although increasing reliance on the telephone (for booking appointments or for triage, for example) ostensibly helped patient through-flow, and was favoured by some patients, it could also contribute to inequity in access. The telephone potentially disadvantaged particular patient groups, including those with language differences and hearing impairments. The early morning 'phone lottery' for same day appointments was a source of frustration for reception staff and patients. Within primary health care more broadly, Out Of Hours care appeared detached from General Practice, and at a wider system level the ED could be viewed as a way to 'cut out the middle man' and access appropriate care in a straightforward manner.

It is apparent from our data that access is not merely about availability of GP appointments, but includes a diversity of concerns, such as whether methods of accessing care are simple and reliable. Decisions about where to seek care have been conceptualised as 'depth decisions';(24:65) complex, multi-stage decisions that hold potentially significant implications. Our data support the concept of candidacy, where eligibility for health care is formed via negotiation between the patient and health care service/provider.(25-28) For interviewed patients, perceptions of a mismatch between a GP's view of candidacy and their own could influence decisions to seek care elsewhere.(cf. 26) Furthermore, our data show how patient decision making is informed by cumulative past experience, i.e., there is a recursive nature to access. (24, 27, 28) As a result, seemingly minimal past experiences such as having to wait in a telephone queue to speak with GP reception staff, or a long wait for a routine appointment can inform a global view of primary health care as an inappropriate source of urgent care at a later point. This may help account for the relatively low proportion of patients in our study who sought help from primary health care prior to their index ED attendance(s), which corresponds with other studies.(29) The multiplicity of innovations to enhance access and the way they have been implemented has been described as complicated, resulting in greater system complexity and overlapping services.(30) It was clear in our study that this

complexity was a significant implicit factor in ED use, and had consequences for continuity of care, as described elsewhere.(31, 32)

Our data have implications for practice and policy. Within individual GP practices (and within primary health care collectively), there is unlikely to be a 'one size fits all' approach to access. Practices in our study were attempting to meet the needs of the majority of their patient population, but in doing so could inadvertently disadvantage some groups, often those who experienced particular obstacles to accessing care. Priority should be given to enhancing the transparency and flexibility of appointments systems to build trust and facilitate equity of access. The burden for negotiating access to care largely falls on GP receptionists, and the complexity of their role demands recognition and adequate support.(33) A shift from a patient education model, which imposes ideology on patients, to one that openly engages with differences between patient and provider perspectives can help overcome issues such as semantics and help move beyond the idea of 'inappropriate' demand driven by patients, and showing an awareness of how all interactions recursively inform patients' perceptions and help seeking behaviour.(28) ED departments themselves also have a role in deflecting patients back to primary health care. The reactive and cumulative approach most practices in our study took to appointments systems reflects the huge pressures they face due to a combination of demand which substantially exceeds supply and attempting to respond to frequent changes in health care policy. Our analysis shows that it is not availability of appointments alone that influences decisions to attend the ED. This supports the argument that initiatives that focus on availability of care, such as Extended Access, are unlikely to be a panacea for rising rates of ED use.(7, 8) Instead, a holistic approach that incorporates differing dimensions of access (34, 35) and accommodates the complexity of patient decision making is needed.

There were limitations to this study that could be addressed in future research. Recruitment of patients and carers was difficult at times; practices had distinct approaches to recording and using ED data relating to their patients and there was poor response at some practices which required multiple sampling over time to secure interviews with a sufficient number of patients/carers. Whilst we believe that sufficient data were collected to develop a comprehensive and credible account of patient experience, returning to practices for theoretical sampling of additional patients was not possible. More detailed investigation of the experiences of patients with English as an additional language and with patients aged 18-25 would provide insight into the distinctive experiences of these groups. Additionally, ethnographic study of Out Of Hours care provision is needed to evaluate its relationship with ED use and with in-hours care.

Conclusion

We believe that this is the first ethnographic study to purposely explore the ways in which access to UK general practice influences use of the ED. This article challenges the idea of 'patient demand' as primary driver for rising ED use and turns the lens to interactions in primary health care. We propose that help seeking at the ED can be a rational response to care seeking when access to primary care is experienced as complicated and opaque and where previous engagement has failed to meet needs.

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Competing interests

We have read and understood BMJ policy on declaration of interests and declare that we have no competing interests

Co-author contribution

FM was lead researcher on the study and contributed to design, fieldwork and analysis/interpretation, as well as drafting the manuscript and revisions. EB was a researcher on the study and conducted fieldwork and analysis/interpretation, and made a significant contribution to manuscript revisions. LW and KC contributed to study conceptualisation, design and interpretation of data and made a significant contribution to manuscript revisions. DL contributed to study conceptualisation, interpretation of findings and made a significant contribution to manuscript revisions. AH, PT, CS and RM contributed to interpretation of the data and provided feedback on the manuscript. SP was principal investigator for the study; she led the design, supervised the project and its staff, and made a significant contribution revising the manuscript. All authors approved the final version of this manuscript.

Data Sharing

Data (field notes and interview transcripts) are identifiable and so are not available.

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Why do patients seek primary medical care in Emergency Departments? An ethnographic exploration of access to general practice.

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Why do patients seek primary medical care in Emergency Departments? An ethnographic exploration of access to general practice.

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ABSTRACT

Objectives

To describe how processes of primary care access influence decisions to seek help at the Emergency Department (ED).

Design

Ethnographic case study combining non-participant observation, informal and formal interviewing.

Setting

Six GP practices located in three commissioning organisations in England.

Participants and methods

Reception areas at each practice were observed over the course of a working week (73 hours total). Practice documents were collected and clinical and non-clinical staff interviewed (n = 19). Patients with recent ED use, or a carer if aged 16 and under, were interviewed (n = 29).

Results

Past experience of accessing GP care recursively informed patient decisions about where to seek urgent care, and difficulties with access were implicit in patient accounts of ED use. GP practices had complicated, changeable systems for appointments. This made navigating appointment booking difficult for patients and reception staff, and engendered a mistrust of the system. Increasingly, the telephone was the instrument of demand management but there were unintended consequences for access: some patient groups, such as those with English as an additional language, were particularly disadvantaged, and the varying patient and staff semantic of words like 'urgent' and 'emergency' were exacerbated during telephone interactions. Poor integration between in and out of hours care and patient perceptions of the quality of care accessible at their GP practice also informed ED use.

Conclusions

This study provides important insight into the implicit role of primary care access in use of the ED. Discourses around 'inappropriate' patient demand neglect to recognise that decisions about where to seek urgent care are based on experiential knowledge. Simply speeding up access to primary care or increasing its volume is unlikely to alleviate rising ED use. Systems for accessing care need to be transparent, perceptibly fair, and appropriate to the needs of diverse patient groups.

ARTICLE SUMMARY

Strengths and limitations

- Helps explain how interactions in primary health care can influence help seeking behaviour.
- Draws attention to modifiable features of primary health care that have the potential to help reduce ED use.
- Provides a detailed description based on both actual observed practice and individual narrative
- Patients/carers interviewed may not be representative of all those self-referring to the ED. Recruitment of patients was via GP practices, and it is possible that they may either have 'an axe to grind' or be reluctant to criticise.

BACKGROUND

The number of people seeking urgent health care in Emergency Departments (EDs) has risen to record levels in the NHS in England, with over 2 million *monthly* attendances recorded for the first time in March 2016.(1) This has had significant implications for delivering national urgent care policy, as the increasing number of attendances has been associated with a continuing decrease in performance of the national 'four hour standard', whereby EDs should assess, diagnose, treat and either discharge home or admit to hospital teams within four hours of arrival at the ED.(1) Given that a significant proportion of ED attendances are self-referred (patients choose to attend ED, rather than going to their GP), are discharged with 'advice only' (treatment in an acute hospital setting was not required) and that ED attendances peak during the working day on a Monday,(2, 3) it is presumed that better access to primary care will relieve pressure on EDs. This in turn could improve the performance of EDs in the NHS and help them to deliver the four hour standard by reducing pressure on fixed resources of staff, clinical space and diagnostic support services.

Given this, and that access is considered to be a central feature of high quality health care,(4) it seems evident that initiatives to improve primary care access are of value. Rapid access to primary health care in England is incentivised, with reward based on performance in the annual patient survey in primary care. In response to this, many GP practices sought to implement the 'advanced access' model that has been adopted effectively in the USA,(5, 6) and impetus to increase the volume of GP appointments through extending access to weekends and evenings, for example, has grown. Criticism of these approaches has included that the emphasis on speed of access has been to the neglect of other, important, dimensions of access(7, 8) and oversimplify the problem. There have been conceptual and practical barriers to implementing change, both relating to advanced access (6) and increasing the volume of GP access, with initiatives such as the Greater Manchester Primary Care Demonstrator Evaluation failing to provide convincing evidence that increasing the volume of primary care access leads to a reduction in ED use.(9-11)

The factors that determine the choice of location of first health care contact for urgent problems are complex. A review examining influences on ED attendance across different health care systems found a differential impact of access to primary care although some studies were limited by their methods of analysis.(12) Recent quantitative analysis of the relationship between access measures in primary care and ED attendance in England have found that even after adjustment for potential confounders, patient reports of poorer access to primary care were associated with increased ED attendance.(2, 12-16) Qualitative studies of ED use often focus on 'appropriateness' of use and patient motivations for location of care seeking, highlighting discrepancies between patient and

provider views(17-23)Some qualitative data on ED use demonstrates the complexity of decisions about where to seek care, framing demand as rational. (19)

In order to understand in more detail how the processes of primary care access can affect the decisions made by patients over their choice of first contact healthcare provision for urgent problems, we designed an ethnographic study at the critical interface between the community and its primary care practice – the reception area and its team that implement the process of access to clinicians. Our objective was to provide a nuanced account of how interactions that take place when patients seek urgent primary health care might inform decisions to seek help at the ED.

METHODS

Design

We conducted an ethnographic case study of six General Practices. Multiple methods were employed to achieve detailed and contextual insight, including: non-participant observation, individual interviews, and analysis of documents. The ethnography research team comprised three social scientists (EB, FM, LW) and an academic GP (KC).

Setting and sampling

We chose six GP practices across three commissioning organisations (clinical commissioning groups). Using routine data from three years (2009-10, 2010-11, 2011-12), GP practices within each commissioning area were stratified into quintiles by rate of ED use and unplanned hospital admissions. These data were scrutinised to identify potential cases, e.g. practices which seemed to have lower unscheduled care use than might be expected given population characteristics (such as high levels of deprivation, large older population), pairs of practices with relevant shared characteristics but very different rates of unscheduled care use and practices that had moved significantly between quintiles. Selected practices varied in features such as size and diversity of the patient population, staffing and area deprivation (TABLE 1).

Table 1: Practice characteristics

Practice	Commissioning area	List size as percentage of commissioning area average	Quintile on Index of Multiple Deprivation	Full Time Equivalent GPs /1000patients (commissioning area average)	Observation period (total hours)
1	1	67.9%	2nd most deprived	0.476 (0.54)	Oct/Nov 2013 (18 hours)
2	1	139.5%	2nd most deprived	0.52 (0.54)	Feb 2014; May 2014 (14 hours)
3	1	58%	Most deprived	0.62 (0.54)	Feb 2014; May 2014 (14 hours)
4	2	209.6%	4th least deprived	0.5 (0.6)	June 2014 (10 hours)
5	2	225.6%	2nd least deprived	0.51 (0.6)	June 2014 (9 hours)
6	3	197.4%	2nd most deprived	0.54 (0.57)	July 2014 (8 hours)

A sample of patients/carers with recent experience of ED use were invited to interview. Participating practices generated anonymised lists of patients with recent (≤ 3 months) ED use. Those patients who had self-referred to the ED, who attended the ED during GP practice opening hours, who had no investigations while at the ED, and/or who were discharged with 'advice/guidance only' were approached first, as the potential to have had needs met in primary health care was considered to

be higher in this group. A range of clinical and non-clinical staff at participating practices were also invited to interview by the practice's research contact or during observation by the researcher. Informal interviews supplemented recorded staff interviews.

Data collection

Non-participant observation took place between October 2013 and July 2014. Consent was sought at the practice level for observations. Observation took place in the reception and 'back office' administrative areas, as we wanted to look at interactions with patients, between practice staff and between practice staff and other health care professionals to gain insight into practice factors and how these might influence patients' care seeking. The observing researcher wrote field notes in a notebook during events, or shortly afterwards. Much of what was observed was telephone interactions, and where necessary these were followed by informal discussion with staff to gain clarification. The observer also collected relevant documents (e.g., policies / guidelines for staff, meeting notes, patient information leaflets).

Staff interviews sought to get insight into their experiences of patients seeking urgent care and views of their workplace's policies and practices around access. In some instances the invitation was issued to all staff at a practice meeting or in staff pigeonholes and staff then approached the researcher to express interest. At other practices individual staff were identified and approached by the practice contact (e.g. research lead). The process was iterative, and some potential interviewees were identified by the researcher as a result of data collection. For example, at one practice, patient and staff interviewed frequently mentioned a particular GP, who seemed to be the preferred GP for patients with higher rates of ED attendance, and so this person was approached and subsequently interviewed. Interviews were audio-recorded with written consent and a topic guides was employed to facilitate discussion.

Patient/carer interviews sought to understand pathways to the ED and experiences and views of the practice. Identified patients (or carers for patients aged 16 and under) were sent invitation letters by their GP practice, with a reply slip to be returned directly to the researcher. As with staff interviews, patient/carer interviews were audio-recorded with participants' consent and a topic guide was used.

Analysis

Field notes and documentary analysis were transcribed into MS Word by EB. A structure to the typed field notes developed from the first two practices, which was applied to subsequent practices. This included: information about the practice (population, staffing, summary of results from the most recent GP patient survey etc.), description of the practice context, a diagram of the practice layout, and a description of observed interactions. The field notes were read to identify themes specific to the practice and also cross-cutting themes (e.g., 'Being dealt with/seen in a timely manner at reception or for booked care', and 'unscheduled secondary care – specific references'), and a description of these was written by EB. Interviews were transcribed verbatim by a professional transcriber then checked for accuracy and anonymised by FM. Transcripts were uploaded to NVivo 9. FM wrote an interpretive narrative of each transcript and then integrated these in a descriptive account for each practice. The ethnography research team met monthly to discuss the ongoing analysis.

Practice summaries and integration

Field notes and interview descriptive accounts for each practice were reviewed by FM. Over-arching themes relating to how interactions relating to urgent care at each practice influenced ED use were identified and these formed the structure of a case summary for each practice. Each summary was reviewed by the ethnography research team and key findings fed back to the wider research team for discussion. All six summaries were then evaluated together to identify key features of primary health care that influence use of unscheduled secondary care.

The results presented here show how dimensions of access to primary health care are implicit factors in patients' decisions to attend the ED. Results are illustrated with interviewee quotes and extracts from observational field notes; pseudonyms are used for all participants.

RESULTS

Seventy three hours of observation across six practices were recorded in total (TABLE 1). Nineteen members of staff were interviewed (TABLE 2): seven GPs, seven reception staff, four managers and one nurse practitioner. Twenty patients and nine parents/carers were interviewed (TABLE 3), 17 in their own homes and 12 by telephone. Ten patient interviewees spoke English as an additional language: none requested a translator.

Table 2: Staff interviews

Practice	Pseudonym	Role in practice
1	Elizabeth	Lead GP
	James	Reception/administration
	Sally	Reception/administration
	Michelle	Reception/Health Care Assistant
2	Charlotte	Reception and access manager
	Emily	GP
	Olivia	Lead GP
3	Matthew	GP
	Connie	Office manager,
	Paula	Medical secretary / receptionist
4	Becky	Audit controller
	Linda	Reception Manager
	Bronwyn	GP
5	Laura	Patient services manager
	John	GP
	Lindsay	Nurse practitioner/manager
6	Alexander	Reception/administration
	Leah	Quality improvement facilitator
	Sadiq	GP

Table 3: Patient/carer interviews

Practice	Pseudonym	Patient / carer	Sex	Age (age of patient)	Index ED use	English as a first language
1	Orla		Female	58	Multiple self-referral	Yes
	Emma		Female	26	Multiple self-referral	Yes
	Magda		Female	30	Single self-referral	No
	Liang		Male	30 (<1)	Multiple self-referral	No
	Daniel		Male	42	Multiple, plus admitted	Yes
	Candice		Female	48	Multiple, plus admitted	No
2	Jackson		Male	56	Single, plus admitted	Yes
	Sam		Male	48	Single self-referral	Yes
	Fadil		Male	34	Emergency services referral, plus follow up self-referral	No
	Zahirah		Female	28 (2)	Multiple self-referral	No
	Mo		Female	42	Single self-referral	Yes
3	Peter		Male	64	Single, plus admitted	Yes
	Ruby	Carer	Female	27 (2)	Multiple self-referral	Yes
	Sylvia		Female	72	Single self-referral	Yes
	Anna		Female	25	Multiple self-referral	No
	Marilyn		Female	68	Single self-referral	No
4	Rebecca		Female	26	Multiple self-referral	Yes
	Joan	Patient	Female	68	Single self-referral	Yes
	Gemma	Carer	Female	38 (5)	Multiple, plus admitted	Yes
	Noreen	Patient	Female	62	Single self-referral	Yes
	Gabriella		Female	44	Multiple self-referral	Yes
	Mitch		Male	44	Single self-referral	Yes
	Grace	Carer	Female	31 (3, 1.5)	Single (child1); Multiple (child2)	Yes
	Carol		Female	42	Multiple self-referral	Yes
5	Faith		Female	23 (4.5, 1)	Single (child1); multiple (child2) self referral	No
	Suzy		Female	40 (13)	Single self-referral	Yes
	Sharon		Female	31	Multiple self-referral	Yes
6	Aisha		Female	24 (<1)	Multiple self-referral	No
	Mehreen		Female	25 (<1)	Multiple self-referral	No

Whilst features of general practice were not usually explicitly stated by patients as factors in seeking help at the ED, they were implicit in patient accounts, and observed to be important determinants of patient behaviour during fieldwork.

Intricate appointment systems

Highly complex appointments systems that had evolved incrementally over time were typical. Both patients and reception staff found these obscure and hard to navigate; patients mistrusted them, and their operation was affected by the skills and experience of reception staff. Each practice had a unique appointment system, with a range of appointment categories and ways of allocating appointments. Nurse or GP-led telephone triage was used by several practices, and two (5 and 6)

encouraged patients to see the same doctor each time. A general shift towards same day appointments and telephone appointments/telephone triage was evident.

Patient/carer interviews revealed a degree of suspicion amongst patients, and this was recognised by reception staff: "t*hey [patients] think you're hiding appointments"* (Sally, Receptionist, GP practice 1). At practice 2, reception manager Charlotte commented: "*some patients sit in the reception waiting room to wait for the phone call. There's a perception that if they do that then they might be seen".* Factors contributing to a lack of confidence in access systems included ongoing incremental changes to systems that were not clearly communicated to patients and a reliance on the telephone for access. Telephone systems could be overloaded at the start of the day when same-day appointments were generally allocated and patients reported getting 'mixed messages':

> *On the Friday I rang and they said, "You'll have to ring back on Monday." And I said, "Well I need to speak to a doctor as well [as well as having a face to face consultation]," and they said, "That'll be next Thursday." I said, "What, a week to speak to a doctor?" But then I rang again on the Monday and somebody said, "Right, somebody will phone you back in two hours." (Mo, patient, GP practice 2)*

Complex appointment system meant reception staff have an important role in facilitating access. Receptionists at all practices engaged to some extent in patient triage, for example by determining level of urgency in appointment requests. Observation of newly appointed staff dealing with appointment requests suggested that knowledge of how the system worked was often tacit and uncodified (Box 1).

Box 1: Reception staff skills and knowledge (observation field notes)

Practice 4: One Monday morning in particular there were regular discussions about whether a doctor or a nurse was more appropriate, with receptionists sometimes seeming to be seeking to 'sell' nurses to patients by stating that they could prescribe, and that the wait might be shorter (Experienced receptionist Linda "Would you be happy to see a nurse practitioner? She can prescribe."). The new receptionist Beth was observed routinely asking patients if they needed to see a nurse or a doctor ("Do you need to see a doctor or can you see a nurse?"), effectively placing the responsibility on the patient to choose with the implied assumption that they knew who could deal with what. Some patients did know – for example they had past experience of a similar problem and knew it was unlikely to be something the nurse would be able to prescribe for. Others were more uncertain at being allocated this self-triage role by Beth.

09:01 A man with a young boy is being served by Beth. He says he was told on the phone to come down but there are now no appointments left with the person he wanted to see. Linda joins Beth and tells the man that the boy will be seen. She asks what the problem is. He says tonsillitis and Linda suggests that they see the nurse practitioner.

10:04 Beth is still asking people if the nurse can help. They sometimes respond with a description of the problem they are here about; they want her to triage/make the decision. She puts the man who is currently at the desk down for the nurse. His first language is not English and he continues trying to explain something to her. The more experienced receptionist, Linda, provided guidance and advice, helping the patient and steering them towards what she saw as the best option.

Reception staff were aware of how experience mattered: "*I wouldn't say everybody would know what to look for. I think it's a trained eye*" (Paula, Receptionist, GP practice 3), and Alexander, a receptionist at GP practice 6 describes how *"you have to kind of read between the lines most of the time"* when eliciting information from patients. When asked about how he would decide whether do pass a call to a nurse practitioner or a GP, he said: *"I would base it on the symptoms. I think, you know, having worked here this long I have a good understanding of what the nurse practitioners are capable of*".

For patients, reception staff were seen as 'gatekeepers', *"If you call you speak to a receptionist, you feel like you've got to get past that first, you know, enough to get an appointment"* (Grace, patient, GP practice 4). As discussed earlier, patients might feel that reception staff were obstructing access. However, observation suggested rather that staff used the system flexibly to facilitate access. In informal discussion Rhona, a receptionist at GP practice 1 told us: *"Sometimes we can manipulate the system, but we try to stick to the appointments".*

Each practice's system reflected their patient population and their priorities. Practice 2, with a significant Muslim population, introduced a Saturday morning clinic to accommodate patients who couldn't attend the practice on Friday afternoons, whilst Practice 1 was set up specifically to

enhance access for 'hard to reach groups'. In Practice 1 there was a significant focus on facilitating access for patients with drug and alcohol misuse problems or who were homeless (Box 2).

Box 2: Practice 1 - Meeting the needs of specific patient populations

Strategies exist to facilitate access to services, e.g., outreach work, maintaining good relationships with external groups such as homelessness charities, and use of the patient warning system:

With particularly vulnerable patients the GP will put a patient warning on…It will pop up a window in the middle of your screen which you have to acknowledge before you can carry on. So it's usually things like "Prioritise appointments with Dr Elizabeth" or permission to use embargo slots for this patient (James, reception)

The high proportion of these vulnerable patients on the list was often mentioned in interviews, with reception staff demonstrating awareness of their needs and life contexts, *"life's so chaotic anyway that they don't remember…we do have to bear in mind that they're not going by times and dates"* (Michelle, Reception/HCA). Observations showed that reception staff were familiar with dealing with drug or alcohol dependent and homeless patients and dealt with them calmly and patiently. Sometimes patients were provided with appointments or prescriptions outside of normal procedures due to a concern that they would "kick off" otherwise

In contrast, this flexible and accommodating approach was not generally applied to patients who had English as an additional language at practice 1. Reception staff experienced language barriers as problematic and disruptive:

> *We just have to try and work out what it is they're saying and we have to try and make ourselves understood and it is difficult. It's really difficult. There's no system currently in place to alleviate that and it's tricky to see how you could. I mean unless you have a member of staff, every single of member speaking a language…And those conversations take ages because you can't hang up if you don't understand (James, Receptionist, GP practice 1)*

As discussed earlier, the intricate systems we observed had generally arisen out of an ongoing process of monitoring and adjustment. For example, Practice 2 changed the number of telephone triage slots each week based on the previous three week's use. Two practices (5 and 6) were particularly focused on increasing efficiency by monitoring and changing their system. At practice 5, Practice Manager Graham described how appointments were allocated based on historical data. For example, Mondays were busy, and so had the highest number of emergency slots. Waiting times for specific doctors were also reviewed, and patients were switched between doctors' lists if waits exceeded 5 days. Practice 6 was unusual in adapting procedures for specific patient populations. For example, they found that telephone triage of young children generally led to face-to-face appointments, so they decided to offer appointments for young children without the need for triage. Alexander (receptionist) notes that the appointments system *"has been tweaked so much over the years*." However, this approach of incremental and reactive system changes--tweaking things—could

be problematic for patients. One patient interviewed, Aisha, said *"Do you know, with appointment it used to be easy? You'd book your appointment and then you'd go in to the doctor."* Similar feelings were echoed by patients at other Practices:

> *I tried to register again [for the booking system] and it was like, "We're not using this system now; we're using a different system." You try and register, and then I didn't ever receive like a confirmation email back and I just kind of gave up and thought, "Whatever, I'll just leave it." (Grace, patient at GP practice 4)*

Appointment availability

Most practices had incrementally increased same day appointments, telephone triage or telephone consultation slots. Staff were generally positive about telephone access/triage, as it reduced demand for face to face appointments and meant that there was always something to offer patients, even if this was simply an instruction to call back the next morning to access triage slots. This approach was common at Practice 1, where staff reported that that the triage list fills up within minutes:

> *There's six appointment slots. You never ever book into triage except on the morning. It's electronically locked until 8.00. People phone up at 8.00, so the phones usually go berserk. (James, receptionist)*

Most practices released same day appointments prior to the practice physically opening, favouring those with access to/preference for the telephone. Some features of appointment systems were opaque to patients; for example, patients from GP practice 1 were rarely aware that additional appointments were released in the afternoon. The existence of different types of appointment could be bewildering:

> *I am not very happy about this part of it. I could go down there now, drive down there and say I'd like to see Dr X or any of the doctors in our practice. .."Right um there's no appointments available until next week. But if you would like to ring at eight o'clock in the morning, tomorrow morning, we will fit you in as an emergency and you will see a doctor". (Peter, patient, GP practice 3)*

The provision of a same day appointments or telephone triage was arguably at the cost of routine appointments (Box 3). Demand for routine appointments was difficult to manage, with waiting times of between 4 and 14 days. Graham, practice manager at practice 5, suggested that this led patients to frame problems as urgent inappropriately. This lack of routine appointments frustrated patients, *"I need to know that I'm going to be ill about two weeks in advance*" (Rebecca, patient, GP practice 4). *A*n emphasis on telephone triage also had the potential to inhibit continuity of care or fulfilment of patient preferences. For example, stated preferences for a particular GP, or with a GP who was female, could not be met in some practices.

Box 3: Reliance on telephone triage (observation field notes)

At practice 2, the vast majority of people who contacted the surgery seeking a GP appointment were told that there were no face to face GP appointments at all available for them to book, and were either instructed to call back on another day to try and book a newly-released appointment a week in advance then, or if they could not wait this long they were offered a call back from the on-call doctor today. It seemed that many patients who would have been satisfied to book an appointment in a few days' time were ending up on the same day triage list because this was not an option.

Monday 08:47: Receptionist Donna, "At the moment all appointments booked for next Monday." "If you ring up today you basically get an appointment for next Monday, but they're all gone. If you need today I can put you down for a call". Patient asks about appointments. "No, nothing, tomorrow release more appointments which are for next Tuesday." Donna offers a call today again. Ends up booking patient into a telephone slot on Thursday after 12:30. Donna's next call: "We don't, they're all gone now." "OK sorry about that, bye, bye."

Weekend and evening appointments and 'walk in' (i.e. no appointment) clinics had been implemented by some practices to meet demand. Demand for appointments at walk in clinics was very high, putting pressure on facilities: in Practice 4 we observed 26 patients in the queue within 10 minutes of doors opening, and there were 47 people in the waiting area before 9am. Extended hours access also did not always work as intended. Practice 5 had evening and weekend access, ostensibly to facilitate access for working people:

> *I think sometimes it's not necessarily busy with the people that maybe need it: people that are working away, that work full-time, that was what it was intended for. But because we've got into a stage where patients couldn't see their doctor for six days, but there was a Saturday morning available, they go, "Oh yes I'll have that." (Laura, Patient Services Manager, GP practice 5)*

GP practice 4 had a higher number of working age patients than other practices, and lack of appointments outside of the working day was noted by three patients during interview.

Communication and talking on the telephone

Practices felt under great pressure: *"even if we worked seven days a week, 24 hours a day, we will never meet demand*" (Emily, GP, GP practice 2), and the telephone had become the instrument of demand management. Whilst practices saw this as beneficial ("*it is pretty much the only way to deal with it [demand]*" Sadiq, GP, GP practice 6), patients and carers interviewed expressed ambivalence about reliance on the telephone. Many appreciated that it could speed up access but also had a disinclination to speak with clinical staff by phone. The morning telephone rush could be problematic; *"some people miss out 'cos there are so many people calling at the same time* (Faith, parent, GP practice 5). Critically, reliance on the telephone had the potential to lead to inequitable access for some groups.

Patients with English as an additional language could be particularly disadvantaged by the telephone's dominance, and we observed notable variation in practice between GP Practices (Box 4), which appeared to drive some ED attendance (practice 1, Box 4). Aisha, parent of a young child at GP practice 6 expressed frustration at what she felt was a convoluted process of accessing care (via telephone triage), and that the outcome was often not worth the effort: *I'm struggling with my English, it's not very good, sometimes you don't know which words you need to use when you are ill. So when you can't explain they say, "You don't need to come here. Just get Paracetamol or Ibuprofen*."

Although only accounting for a small proportion of the patient population, those with hearing difficulties and deaf patients were also constrained by the reliance on telephones:

> ***Practice 2 field notes:*** *A man at the desk is saying "Very peculiar I can't see the doctor". There seems to have being a misunderstanding and he thought he was supposed to come in to see the doctor today but he does not seem to have an appointment. He is getting upset. It seems that he does not have a phone for the doctor to call him back. The receptionist says that she will go and ask the doctor he thought he was seeing. A little later I hear the man say that he is deaf and that he was told two weeks ago by the doctor to come in. He has been told that if he sits and waits Dr Emily will see him but they cannot tell him what time. He is not happy. He says it was Dr A who told him to come. "You make me crazy here. I can't phone, I come and you tell me it is full. I came last week. Any doctor, any week. When will I be able to book a doctor."*

Box 4. Contrasting examples of responding to patients with English as an additional language (observation field notes)

Facilitating access

Practice 2: A couple, who appeared to be Eastern European, come to the reception desk to say that it was past their appointment time but they had not been called. It turned out that they had not checked in when they arrived, as they did not understand that they needed to do this. Tracy responds by sending the doctor they were supposed to see a message to explain the situation and see if she could fit them in late, and she also explained to the couple what to do next time they came for an appointment.

Practice 6: A man comes to Sharon with a four-week-old baby asking about a BCG. Sharon takes him over to the community services desk. It looks like the man with the baby is having some language problems. Sharon asks what language he speaks and then sends for a colleague who speaks Arabic to come and help. …Sharon, to Arabic speaking colleague who has now arrived in reception: "This poor gentleman has been sent round the houses" and then she proceeds to explain what the issues are as she understands them. He will be sent another appointment for a BCG by community services, and then needs an eight week check (the original BCG appointment was missed)…Sharon is telling someone she will book an interpreter for an Arabic speaking man… Sharon is saying "Sorry you have been messed about" to the Arabic speaking man

Inhibiting access

Practice 1: The last walk-in appointment for today is given out at 16:31. The next man to arrive does not have English as a first language and talks about a "point" in his thigh. Lead receptionist Mary tells him that they have no appointments left and suggests that he call 111. He does this on his mobile phone from the waiting room but he doesn't seem to manage to speak to anyone. Mary suggests that he can come back tomorrow morning and he will be able to sit and wait, or he can go to A&E if it gets too bad in the interim.

Practice 4: 12:24 Beth comes in with a query. A man says he has not been called but the screen is showing him as having been called at 12:00. English is not his first language. Is it something about a sick note? No – he wants to talk to doctor to see what was wrong. Doesn't want to just go back to work. He still wants an appointment to check his health. He is told to phone at 08:30 tomorrow to get an appointment. I don't think he is clear on the instructions he has been given, plus phones very busy at 08:30, phone more challenging when English not a first language, and he wasn't told about the possibility of coming to the downstairs desk from 08:00 on.

Is it an emergency?

All GP practices had a proportion of same day appointments categorised as 'urgent' or 'emergency' appointments, both face to face and telephone. Urgent requests would always be met, usually via GP telephone triage. It was evident in interviews and observation that patients and staff often understood these terms differently, leading to frustration and confusion. Staff claimed that some patients sought urgent appointments inappropriately: *"They know how it works a little bit, so if there's no appointments then they'll make up that's its urgent*" (James, receptionist, GP practice 1). Staff also attributed the demand for urgent appointments to cultural and language differences:

> *I suppose a big thing that plays a factor with the language barrier is that a lot of patients don't really understand the terms 'urgent', 'routine'. A lot of them use the word 'emergency', "It's an emergency," and what they actually mean is – because emergency to us in healthcare is 999, it's a real emergency – whereas what they mean is that their child might have a high temperature (Charlotte, Reception Manager, GP practice 2)*

Long wait times for routine appointments led patients to frame their need as urgent when they otherwise might not. Mo, a patient at GP practice 2, reflects: *"When you needed to speak to a doctor, what do you define as urgent or not urgent, you know?…even if it was the next day, but a week is a bit much".*

'Urgency' was negotiated between patients and staff. Reception staff often supplemented the word 'urgent': *"We've only got medically urgent I'm afraid" "And it is definitely medically urgent?",* or using a timescale: "*Is it urgent for today*?" This then required patients to 'self-triage': "*I sort of say, "Well it's not an emergency-emergency, but I could do with being seen in the next day or so."* (Sharon, patient, GP practice 5). Some patients appeared uneasy with defining their request for an appointment as an 'emergency', and conversely others felt that receptionists should take requests at face value: *"I should know in myself that there is an issue with my mental health and I need to see somebody sooner rather than later, but I don't want to go into a deep rooted conversation with the receptionist". (Rebecca, patient, GP practice 4)*

Out Of Hours care

Complexity within the wider system, particularly around out of hours (OOH) care, could also influence ED use. There was largely a lack of clarity around where to access care out of hours, and there was a widely held view that GP care was only available within practice opening hours. In interviews patients often described not seeking care from primary health care prior to the index ED attendance, ""*I never thought of it*" (Sylvia, patient, GP practice 3). Some were aware of the non-emergency out of hours telephone line 'NHS 111', but did not know that this was a route to out of hours GP care. For other patients, previous experience and assumptions about the quality of OOH care precluded it from being considered a source of help. Gemma (patient, GP practice 4) had taken her daughter to appointments with OOH GPs but felt that they had focused on irrelevant symptoms. She reflects, "*We completely lost hope in the out of hours doctors*". Other participants, particularly those with long term conditions, found the lack of information available to out of hours doctors problematic:

> *it's an emergency appointment, and I'm in pain, and I'm looking for something to help...she was asking me all these questions about, you know, drug seeking and am I addicted and how long have I been taking these drugs? And she hadn't read the notes that led to that (Emma, Patient, GP practice 1)*

In contrast to OOH, experiences in the ED or using the NHS 999 emergency telephone number were largely positive. When asked what he would do about accessing care out of hours in future, Fadil (patient, GP practice 2) says, "*To be honest with you, I'll call 999*".

Practice staff felt that a lack of awareness of OOH services drove ED use: "*I don't think a lot of patients are aware of out of hour's services. I think if they were then A&E wouldn't be so snowed under*" (Michelle, Receptionist, GP practice 1). Practices did not seem to feel responsible for promoting OOH care: "*I'm not sure what we actually do, other than have a phone message*" (Sadiq, GP, GP practice 6).

Perceptions about level of care accessible at GP practice

Some patients who had attended the ED described their ED attendance as the fastest route to appropriate care. Grace (patient, GP practice 4) describes it as 'cutting out the middle man', drawing on experiences of accessing care to contextualise this:

> *I wouldn't necessarily have rung a GP surgery because I think they probably would have told me to go to A&E. I guess I'm second guessing myself, but in my head I think that when I try, you know, to get appointments on a day to day basis they generally don't have appointments, and if there was anything wrong they would probably refer me to A&E, so it's kind of a bit like cutting out the middle man.*

Some patients described being dissatisfied with care and questioned their GP's competence, or felt that the ED could offer them a level of specialist skill unavailable in primary health care. The ED provided a level of reassurance that some patients thought would not be possible in primary health care: "*it wasn't very nice being linked up to the ECG machine and having needles stuck in me, but felt like there was a lot more investigation done"(Rebecca, patient, GP practice 4).* Mitch (patient, GP practice 4) had a painful, swollen spot on his back that he thought might be an infected insect bite. Unlike most other participants, he had consulted the GP prior to attending the ED. He anticipated that the GP would want to lance the lump but was instead given antibiotics. Mitch was sceptical about whether these would work, *"I wasn't given any sort of advice going forward*." Subsequently, as the pain and swelling continued, he decided to go to the ED:

> *there probably was an alternative but I just thought to myself, "I wanna get this sorted," and I thought the best way to do it was to go to the A&E*

Despite babies and young children having preferential access to GP care (e.g., children under two offered same day appointments), parents/carers could feel that their views were disregarded by GPs and perceive that they received a better quality of care in the ED. Risk perception dominated parent and carer accounts (Mehreen's story, Box 5), so the ED was seen as more appropriate when they viewed problems as urgent.

Box 5. Patient story: Mehreen

Mehreen's 18 month old son was born 10 weeks pre-term and spent time in Neonatal Intensive Care. Mehreen felt that the decision to go to the ED the first time she attended with her son (for "very severe colic") was influenced by her experiences at NICU:

When he get discharged on that time they said like, "He is premature. If he has any problems straight away you can come into hospital."

More recently, Mehreen's son developed a fever that she managed at home with paracetamol for a few days. The fever wasn't responding to paracetamol and she went to the ED where *"they just gave the Ibuprofen to him*". Two days after returning home her son developed another fever and she took him back to the ED. This time they investigated to see if there was an infection (urine sample, x-ray, blood test) but no underlying cause was found and the fever diminished while they were at the ED. Mehreen contrasts primary health care with the ED, she feels that in both places she is treated "nicely" but that the quality of care and availability of equipment to investigate problems in the ED is better:

It is different because in the hospital there are really very – give very good – provide very nice care to my baby

Mehreen says that she didn't think to contact her GP because her son's fever was always at night, but her narrative suggests factors that influenced where to seek help other than GP availability. For example, she felt that the call back system does not lead to timely care, and this is especially important in the context of young children:

We have to wait for the doctor's call, because sometimes it's really very emergency and we have to ring to the GP in the morning time because they don't give any appointment if we ring at 12 o'clock, but if we ring before 8 o'clock or 9 o'clock then they give the appointment on the same day. Yeah so I don't like that thing: they need to improve it...Like if we had any emergency at one o'clock, they don't give any appointment on the same day. That's why we prefer go the emergency, because we know the kids are very important in everyone's life.

Along with an expectation that she won't get a timely GP appointment, especially if she calls later in the day, Mehreen feels that concerns about her baby are often dismissed or minimised:

If we went to the GP I don't think so they bother anything…the GP they just said like, "There is not any problem, your kids are happy, there is not anything to worry about it." Because we are mums so we definitely worried about our babies' lives… I know they just give Paracetamol

DISCUSSION

Patients seeking care at the ED often doubted primary health care's capacity to respond to 'urgent' problems. This belief results from cumulative past experience of care seeking. Dimensions of access to primary health care were implicit in all patient accounts of ED use, and observation of practice evidenced these. Different dimensions interacted with one another, and with other features of primary health care such as relational continuity. We found that GP practices had complex appointments systems that had often evolved incrementally and reactively, with new approaches 'bolted on' to try and manage demand. Patients found them obscure and were mistrusting of them; reception staff were required to help patients navigate appointments, which privileged tacit knowledge and expertise. Although increasing reliance on the telephone (for booking appointments or for triage, for example) ostensibly helped patient through-flow, and was favoured by some patients, it could also contribute to inequity in access. The telephone potentially disadvantaged particular patient groups, including those with language differences and hearing impairments. The early morning 'phone lottery' for same day appointments was a source of frustration for reception staff and patients. Within primary health care more broadly, Out Of Hours care appeared detached from General Practice, and at a wider system level the ED could be viewed as a way to 'cut out the middle man' and access appropriate care in a straightforward manner.

It is apparent from our data that access is not merely about availability of GP appointments, but includes a diversity of concerns, such as whether methods of accessing care are simple and reliable. Decisions about where to seek care have been conceptualised as 'depth decisions';(24:65) complex, multi-stage decisions that hold potentially significant implications. Our data support the concept of candidacy, where eligibility for health care is formed via negotiation between the patient and health care service/provider.(25-28) For interviewed patients, perceptions of a mismatch between a GP's view of candidacy and their own could influence decisions to seek care elsewhere.(cf. 26) Furthermore, our data show how patient decision making is informed by cumulative past experience, i.e., there is a recursive nature to access. (24, 27, 28) As a result, seemingly minimal past experiences such as having to wait in a telephone queue to speak with GP reception staff, or a long wait for a routine appointment can inform a global view of primary health care as an inappropriate source of urgent care at a later point. This may help account for the relatively low proportion of patients in our study who sought help from primary health care prior to their index ED attendance(s), which corresponds with other studies.(29) The multiplicity of innovations to enhance access and the way they have been implemented has been described as complicated, resulting in greater system complexity and overlapping services.(30) It was clear in our study that this

complexity was a significant implicit factor in ED use, and had consequences for continuity of care, as described elsewhere.(31, 32)

Our data have implications for practice and policy. Within individual GP practices (and within primary health care collectively), there is unlikely to be a 'one size fits all' approach to access. Practices in our study were attempting to meet the needs of the majority of their patient population, but in doing so could inadvertently disadvantage some groups, often those who experienced particular obstacles to accessing care. Priority should be given to enhancing the transparency and flexibility of appointments systems to build trust and facilitate equity of access. The burden for negotiating access to care largely falls on GP receptionists, and the complexity of their role demands recognition and adequate support.(33) A shift from a patient education model, which imposes ideology on patients, to one that openly engages with differences between patient and provider perspectives can help overcome issues such as semantics and help move beyond the idea of 'inappropriate' demand driven by patients, and showing an awareness of how all interactions recursively inform patients' perceptions and help seeking behaviour.(28) ED departments themselves also have a role in deflecting patients back to primary health care. The reactive and cumulative approach most practices in our study took to appointments systems reflects the huge pressures they face due to a combination of demand which substantially exceeds supply and attempting to respond to frequent changes in health care policy. Our analysis shows that it is not availability of appointments alone that influences decisions to attend the ED. This supports the argument that initiatives that focus on availability of care, such as Extended Access, are unlikely to be a panacea for rising rates of ED use.(7, 8) Instead, a holistic approach that incorporates differing dimensions of access (34, 35) and accommodates the complexity of patient decision making is needed.

There were limitations to this study that could be addressed in future research. Recruitment of patients and carers was difficult at times; practices had distinct approaches to recording and using ED data relating to their patients and there was poor response at some practices which required multiple sampling over time to secure interviews with a sufficient number of patients/carers. Whilst we believe that sufficient data were collected to develop a comprehensive and credible account of patient experience, returning to practices for theoretical sampling of additional patients was not possible. More detailed investigation of the experiences of patients with English as an additional language and with patients aged 18-25 would provide insight into the distinctive experiences of these groups. Additionally, ethnographic study of Out Of Hours care provision is needed to evaluate its relationship with ED use and with in-hours care.

Conclusion

We believe that this is the first ethnographic study to purposely explore the ways in which access to UK general practice influences use of the ED. This article challenges the idea of 'patient demand' as primary driver for rising ED use and turns the lens to interactions in primary health care. We propose that help seeking at the ED can be a rational response to care seeking when access to primary care is experienced as complicated and opaque and where previous engagement has failed to meet needs.

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Competing interests

We have read and understood BMJ policy on declaration of interests and declare that we have no competing interests

Co-author contribution

FM was lead researcher on the study and contributed to design, fieldwork and analysis/interpretation, as well as drafting the manuscript and revisions. EB was a researcher on the study and conducted fieldwork and analysis/interpretation, and made a significant contribution to manuscript revisions. LW and KC contributed to study conceptualisation, design and interpretation of data and made a significant contribution to manuscript revisions. DL contributed to study conceptualisation, interpretation of findings and made a significant contribution to manuscript revisions. AH, PT, CS and RM contributed to interpretation of the data and provided feedback on the manuscript. SP was principal investigator for the study; she led the design, supervised the project and its staff, and made a significant contribution revising the manuscript. All authors approved the final version of this manuscript.

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